Spire Cambridge Lea Hospital

Quality Report

Spire Healthcare Limited
Spire Cambridge Lea Hospital
Quality report
30 New Road
Impington
Cambridge
CB24 9EL
Tel:01233 266900
Website: www.spirehealthcare.com

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Cambridge Lea Hospital is part of Spire Healthcare Limited. Spire Cambridge Lea offers comprehensive services to patients from Cambridge, Suffolk and Peterborough. The hospital is located in the village of Impington, just north of Cambridge and is accessible from the A14 and the M11, as well as being 30 minutes from London Stansted airport.

Healthcare is provided to patients with private medical insurance, those who self-pay and patients referred through NHS contracts. Hospital facilities include an outpatient service, diagnostic imaging service, 15 day-case beds and a 46 bedded inpatient ward. Theatre provision includes five theatres, three of which have laminar flow and an in house sterile services department. From January 2015 to December 2015 there were 7,539 visits to theatre.

We inspected this hospital as part of our independent hospital inspection programme. The inspection was conducted using the Care Quality Commission's comprehensive inspection methodology.

We carried out an announced inspection of Spire Cambridge Lea on 6 June 2016, Following this inspection we also undertook an unannounced inspection on the 20 June 2016, to follow up on some additional information.

The inspection team inspected the following core services:

- Surgery
- Outpatients and diagnostics

All services at this hospital were inspected during our visit.

We rated Spire Cambridge Lea as good overall,with caring as outstanding. Core services achieved good overall in surgery and outpatient and diagnostics.

Our key finding were as follows :

Are services safe at this hospital/service

- Staff were aware of the incident reporting system. There were good examples of incident investigations and root cause analysis (RCA). Learning from incidents was shared with staff and there was evidence of recommendations to improve the service.
- The hospital completed a 'Deep Dive' into all reported patient deep vein thrombosis. Should there be any cause for concern or learning, an RCA would be performed. The report is submitted to the central clinical governance team. This information is logged and analysed quarterly for trends and learning.
- Staff were aware of duty of candour, and we saw evidence of when duty of candour had been applied in conjunction with incidents.
- The hospital collected data to support the safe running of the service on the clinical scorecard. The scorecard was predominantly positive. However, seven out of the 35 clinical outcomes were not consistently met in 2015, but improvements had been made in 2016 in four of these measures, which improved patient safety. The remaining three measures which were not met in 2016 related to the Net Promoter Score measure for patient satisfaction/ feedback. Action plans were in place to monitor improvement.
- The mandatory training target of 95% had been achieved for 2015.
- Safeguarding training had met the hospital's target of 25% per quarter. Knowledge of safeguarding was good, and staff who required level three safeguarding children, for example consultants and matron, had completed the training. The hospital had recently updated the safeguarding training to include female genital mutilation (FGM) and radicalisation.

Summary of findings

- Monitoring of hand hygiene was carried out by measuring hand sanitisation usage, which lacked credibility. The infection control lead nurse had been undertaking local observation hand hygiene audits on a quarterly basis since January 2016 as part of the 'Saving Lives Care Bundle' audit. Spire Healthcare were implementing a national observational hand hygiene audit within the clinical scorecard measures from July 2016.
- Nurse staffing levels across the hospital were planned, met consistently and sufficient.
- A single patient record was not held on site, and we found patient records containing loose notes. The hospital had taken steps to address this and had commenced a pilot of a single patient record at the time of our inspection.
- The World Health Organization (WHO) Five Steps to Safer Surgery checklist was in use at the hospital. However, we observed the completion of a WHO checklist prior to the commencement of a surgical procedure and noted poor practice. On our unannounced inspection the hospital had introduced a new WHO checklist which mirrored the one used in the NHS trust. This had been well received by staff. We observed the checklist being completed appropriately and there was evidence of regular auditing to ensure that the new document became embedded.

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Are services effective at this hospital/service

- Hospital policies were evidence based and we saw examples of where policies had been revised in line with best practice guidance.
- There was a good level of local auditing across the hospital, and good examples of participation in national audits in surgery, for example the Health Protection England surgical site infection surveillance.
- The annual compliance score with pre-operative fasting guidelines for 2015 was 41%, but had increased to 55% in the first three months of 2016. However,
- Patient Reported Outcome Measures (PROMS) data was collected for groin hernia surgery, total knee and hip replacements. All results for this hospital were above the England average for NHS patients.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training compliance was low at 17%. However, this had increased to 70% at end of May 2016, following additional face to face training provided. Staff were knowledgeable about MCA and Deprivation of Liberty Safeguards. There were good processes in place to obtain consent from patients.
- There was evidence of good multidisciplinary team working, between teams and specialists.

Are services caring at this hospital/service

- Friends and Family Test results (July 2015 to December 2015) were consistently above average, scoring between 97 and 100% of people recommending the hospital.
- Patient feedback at the time of inspection was positive, with patients speaking highly of the care and treatment received. Patients and relatives felt involved in decision making.
- A chaperone service was available to support patients undergoing intimate examinations.

Are services responsive at this hospital/service

- Referral to treatment times (RTT) for NHS patients undergoing surgery was within the national expected timescale of 18 weeks for all patients.
- Services were available for patients with additional needs, for example translation services, hearing loops and the ability for relatives to stay with patients who require additional support.

Summary of findings

- The hospital provided formal dementia training and this had met the hospital quarterly trajectory for staff attendance.
- Consultant medical cover was available 24 hours per day, seven days per week via clinics, daily inpatient review, the on call system and resident medical officer (RMO). There was a senior nurse on call rota which provided additional support if there were staffing issues on the ward or patients required to be transferred out into an NHS acute hospital.
- There was a robust system for dealing with, and learning from complaints. We saw examples of where the hospital had worked directly with the complainant to improve services. Outcomes and learning from complaints were shared with staff.

Are services well-led at this hospital/service

- The hospital had a clear vision and strategy underpinned by a set of core values for staff to follow. Staff were aware of the vision and strategy.
- Governance processes were well established, including incident management, audit, policy management and learning from complaints. Information flows between committees were well documented. However, review dates on the hospital risk register were not always recorded. This meant we could not be assured risk management and mitigation was being reviewed regularly.
- The hospital had a consultant dashboard, which included the monitoring of practising privileges. Processes were in place with local NHS trusts to ensure communication in relation to consultants' practice.
- There was an open and transparent attitude to serious incidents which involved duty of candour.
- We reviewed minutes from the medical advisory committee and clinical governance meetings which showed a good level of scrutiny and challenge from a senior level.
- There were examples of innovation and sustainability, such as plans to extend the hospital provision of their Enhanced Recovery Area (ERA) to provide increased capacity to care for level one patients (patients requiring additional monitoring or clinical interventions), with completed staffing competency in place for the end of 2016.

We saw several areas of outstanding practice including:

- There was a system in place which recorded and monitored consultants' competencies, mandatory training, continued professional development, indemnity and revalidation. This information was part of a rolling programme within the medical advisory committee (MAC) meetings, before being signed off by the hospital director and matron in order to re-establish consulting practising privileges.
- The hospital director, matron and MAC chair had clear oversight on the running of the hospital. The director had worked hard to improve staff engagement since coming into post, and had increased the senior management team to improve visibility and to ensure all areas of the hospital were represented at senior level. Staff had nothing but praise for the management team, with exceptional feedback given for the new matron.
- The hospital responded promptly to all areas of concern raised during our inspection, with changes noted on our unannounced visit. However, changes need to be monitored and embedded.

However, there were also areas of where the provider needs to make improvements.

The provider should:

- Ensure that within the theatre department, improvements made concerning equipment and the World Health Organisation (WHO) Five Steps to Safer Surgery checklist are sustainable.

Summary of findings

- Review the Royal College of Surgeons professional standards on consultation for cosmetic surgery and ensure it is working in line with these standards.
- Consider the adequacy of the low compliance target for the percentage of patients being correctly fasted prior to surgery.
- Consider the effectiveness of action planning and follow up to demonstrate improvements.
- Hospital wide and departmental risk registers should be reviewed to ensure that they correlate, and should have a method for capturing review dates, recommendations, actions, responsible individuals, deadlines and dates of completion of actions.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery at Spire Cambridge Lea was rated as good for safe, effective, responsive and well-led, and outstanding for caring. Staff were aware how to report incidents and when this should be done. There was a clear escalation pathway for safeguarding concerns and medication was stored in line with manufacturers' guidance. There were processes in place to report and investigate surgical site infections. The hospital completed a 'Deep Dive' into all reported patient deep vein thrombosis. Should there be any cause for concern or learning, an RCA would be performed. The report is submitted to the central clinical governance team. This information is logged and analysed quarterly for trends and learning. Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients. Appropriate infection control procedures were in place and the environment was clean and utilised well. All areas were staffed appropriately by a skilled, supported and competent workforce. Staff had a good level of knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Staff were able to give appropriate examples and uses of the MCA and Deprivation of Liberty Safeguards. Surgical site infection (SSI) data for 2015 showed that SSI rates for hip arthroplasty operations were slightly above the Spire national target. Regular monitoring of the SSI rate was taking place through the hospital's governance system. No trends in these incidents had been identified and there were no further SSIs between January and May 2016 2016. There were no SSIs for knee arthroplasty procedures reported in 2015 or between January and May 2016. A single patient record was not fully embedded. However, the hospital had an action plan in place, and a pilot had been commenced at the time of our inspection. Hospital policies were evidence based and referenced to national guidance and legislation.

Summary of findings

Pain relief was readily prescribed for patients post operatively to take home. The hospital had recently set up a pain management group to review best practice.
Patient Reported Outcome Measures (PROMS) data was collected for groin hernia surgery, total knee and hip replacements using the Oxford Hip and Knee score. All results for this hospital were within range of the England average for NHS patients.
Patients all reported overwhelmingly positive experiences. Patients felt the care received exceeded their expectations. Friends and Family Test data showed between 97% and 100% of patients would recommend the service. Provisions were in place to accommodate patients whose first language was not English.
There was a clear strategy and vision. Patient feedback was actively sought through questionnaires, and patient forums were held during the year. There was a good governance structure in place. Investigations and RCAs were detailed. Lessons learnt and changes in practice were clearly identified and shared with staff.

Outpatients and diagnostic imaging

Good

Outpatient and diagnostic imaging services were rated as good for safe, caring, responsive and well-led. Effective was inspected but not rated.
There was an open culture of reporting and staff were encouraged to learn. There was a clear process in place for ensuring that consultants' practising privileges were monitored.
Patients were provided with appropriate information to inform them about their hospital visit, including a hospital letter and any relevant patient information leaflets.
All consultants who saw children, and relevant members of the outpatients staff, were trained to level three safeguarding children and young people. There was a registered nurse (child branch) to support paediatric patients and their families or carers.
Staff had a good level of knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had good knowledge in relation to consent and mental capacity.
Monthly monitoring of patient waiting times for clinics was recorded. Patients we spoke with told us that generally they did not have to wait for more than five

Summary of findings

to 10 minutes once they had arrived to go into their appointment. “Did not attend” (DNA) monthly rates were recorded and the hospital had a tracking system in place to monitor this.
Patient feedback was positive and patients spoke highly of the care they had received. “You said, we did” posters were displayed in patient waiting areas and chaperones services were available at patients’ request.
Governance systems were well established and there was evidence of good communication through the relevant committees to staff. Patient feedback was sought through surveys which enabled developments and service improvements.

Summary of findings

Contents

Good

Spire Cambridge Lea

Services we looked at

Surgery and Outpatients and diagnostic imaging

Summary of this inspection

Background to Spire Cambridge Lea Hospital

Spire Cambridge Lea is a purpose built hospital which was opened in 1987, which was commissioned and built by HCA hospitals before being sold to BUPA in 1989. The original hospital consisted of 30 beds, two theatres, four consulting rooms and a general x-ray room. Over the past 20 years the hospital has expanded and now has 61 beds, five theatres, three of which have ultra clean ventilation, an endoscopy unit, an in house accredited sterile services department, fixed site MRI, CT, ultrasound room, digital mammography, general x-ray and 22 consulting rooms.

In 2007 a private equity company called Cinven bought the company from BUPA Hospital LTD and Spire Healthcare was established. Spire Healthcare became a public limited company when it floated on the stock exchange in July 2014.

The hospital is located in the village of Impington, just north of Cambridge and is accessible from the A14 and the M11, as well as being 30 minutes from London Stansted airport.

The Registered Manager is William Knights, who has been in the post for four years and seven months.

Our inspection team

Our inspection team was led by :

Inspection Manager : Lorraine Bess, Care Quality Commission

The team included four CQC inspectors, one assistant inspector and three specialist advisors: one surgical consultant, one theatre nurse and one governance nurse.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection was announced and took place on 6 June 2016. We also undertook an unannounced inspection on 20 June 2016, to follow up on some additional information.

Before inspecting, we reviewed a range of information, including information held by us and information provided by the hospital. In addition to private healthcare services, the hospital also treats NHS funded patients and we contacted the main clinical commissioning groups (CCG) for their views on the hospital.

We talked with patients and staff from the ward, operating theatre and outpatient services. We observed how people were being cared for, talked with carers and/or family members and reviewed patients records. We also undertook a focus group at the hospital on 6 June 2016, for a variety of staff to attend.

Patients' views were also collected by means of comment cards in the immediate weeks running up to and immediately following the inspection.

We would like to thank all the staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Spire Cambridge Lea.

Summary of this inspection

Information about Spire Cambridge Lea Hospital

Key figures:

Summary of beds:

Overnight beds 46

Day case beds 15

Staff:

Medical - Doctors working under rules or privileges 231

Doctors and dentists employed 0

Nursing – 66 wte

Operating department practitioner – 9.6 wte

Care assistant – 14.9 wte

Other – 123

Inpatient activity summary (January to December 2015)

NHS funded – 588

Other funded – 1878

Outpatient activity summary (January to December 2015)

NHS funded – 479

Other funded – 4594

There were 7,539 visits to theatre between January 2015 and December 2015. The five most common procedures performed were :

Phacoemulsification of lens with implant –unilateral (849)

Diagnostic colonoscopy, include forceps biopsy of colon and ileum (428)

Diagnostic oesophago-gastro-duodenoscopy (OGD) , include forceps biopsy of colon and ileum (312)

Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (278)

Diagnostic endoscopic examination of bladder (flexible cystoscopy) including biopsy (196)

Diagnostic Imaging facilities on site include CT scanning, Dexa scanning, fluoroscopy, general x- ray, mammography, MRI scanning, Orthopantomogram, theatre imaging and ultrasound.

The accountable officer for controlled drugs is William Knights.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Good

Surgery

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Information about the service

Spire Cambridge Lea provided a wide range of surgical services within the following specialities; orthopaedic, ear, nose and throat (ENT), general surgery, urology, ophthalmic, spinal and pain. The hospital also provided gynaecology and cosmetic surgery services.

The hospital had one inpatient ward with 42 single-occupancy rooms with en-suite bathroom and one four-bedded bay with shared bathroom and toilet facilities. There was also a short stay suite which had 15 single occupancy bays.

At the time of our inspection there was no provision for care of critically ill patients. This service had been suspended pending a full review and was due to be reinstated at the end of 2016. The provision would include two beds where level one critical care patients could be cared for.

There were five theatres in operation at the hospital, three with laminar flow, and these ran Monday to Friday from 8am to 8pm and on Saturday from 8am to 5pm. There was a six bedded recovery area as well as a dedicated endoscopy theatre. During 2015 there were 7,543 visits to theatre.

Patients who accessed these services were either self-funding, privately insured or had been referred for NHS treatment. During 2015 there were 7,539 inpatient stays, NHS patients accounted for 2,466 of these.

During this inspection we spoke to staff members including nursing staff, medical staff, senior management and support staff. We reviewed documentation and data relating to the performance of the hospital and we reviewed five sets of patient records. We spoke with patients and gathered feedback from people using the service in the run up to our inspection by asking them to complete comment cards.

Good

Surgery

Summary of findings

We have rated surgery services at Spire Cambridge Lea as good overall. All domains, with the exception of caring which has received an outstanding rating, were rated as good.

This was because there was an excellent incident reporting, investigation and feedback system and the hospital had good systems and processes to monitor its safety. Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients.

Appropriate infection control and medicines management procedures were in place and the environment was clean and utilised well. All areas were staffed appropriately by a skilled, supported and competent workforce.

Patient care was at the heart of the service and we saw several areas of outstanding practice, including the emphasis on supporting people emotionally and socially. The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as “outstanding” and “amazing.”

Policies and procedures were developed using relevant national best practice guidance and the hospital developed its own local procedures to support staff and promote effective patient care.

The service was planned and delivered to meet the needs of the patient groups it served. Patient access and flow was seamless and without delay and staff were aware of their responsibility to ensure patients individual needs were met.

The hospital had a clear vision and set of values in place and staff were aware of these. The leadership team was proactive and promoted an open door culture. The service was supported by a clear governance structure which encouraged learning and improvement particularly from incidents and complaints.

However, we did note some areas where the hospital should consider making improvements.

We found that review dates or risk assessments post mitigation in action plans were not always undertaken which meant it was difficult to track and demonstrate improvement. We could not be provided with evidence which demonstrated that the Royal College of Surgeons professional standards had been audited to ensure compliance.

We found that a high percentage of patients were not correctly fasted prior to surgery. We noted the on-going work to resolve this.

At our announced inspection our findings demonstrated that the theatre department did not operate effectively to ensure the appropriate use of equipment or the WHO checklist. However, at our follow up inspection action had been taken to address these concerns.

Good

Surgery

Are surgery services safe?

Good

Safe has been rated good for surgery services because:

- There was an excellent incident reporting, investigation and feedback system. This was particularly exemplary within the Short Stay Suite.
- The hospital had good processes to monitor how safe it was using the NHS Safety Thermometer for relevant NHS patients and its own clinical scorecard.
- Appropriate infection control procedures were in place and the environment was clean and utilised well.
- There were robust and compliant medicine management procedures.
- Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients.
- The enhanced recovery area being set up was well managed with clear policies and processes.
- Staffing levels were appropriate and patient acuity was monitored on a daily basis. Staffing levels were increased or decreased as necessary.
- Staff received mandatory training and there was a good level of completion.

However:

- The theatre department did not operate to ensure the appropriate use of equipment or the WHO checklist. However, at our follow up inspection action had been taken to address these concerns, with the replacement of faulty equipment and the implementation of a new WHO checklist.
- There was a high incidence of patients developing a venous thromboembolism (VTE). Root cause analysis (RCA) and "Deep Dive" investigations had been carried out when a patient developed a pulmonary embolism (PE) or deep vein thrombosis (DVT). No themes or trends had been identified.
- Surgical site infection (SSI) data for 2015 showed that SSI rates for hip arthroplasty operations were slightly above the Spire national target. The hospital had made a 50% improvement from its 2014 position, and there had been 0% incidence in 2016.
- Hand wash sinks within the hospital were not compliant with Health Building Note (HBN) 00:09, Infection Control in the Built Environment. Sinks were not free from overflow and plug and they did not have mixer elbow operated taps. However, we noted appropriate medium and long term mitigation plans.
- The service had not yet developed a single patient record. However, a pilot for the introduction of a single patient record was being run at the time of our inspection.

Incidents

- We spoke with four members of staff who were aware of their responsibilities to report incidents through the hospital's reporting system, Datix. Each member of staff gave appropriate examples of the types of incident which required reporting. During 2015 the service reported 301 adverse incidents or near misses and 85% of incidents were investigated and closed within 45 days of reporting. We saw that these had been collated and analysed and the top three reported incidents were medication errors, documentation incidents and cancellations on the day of surgery. This indicated a healthy and open reporting culture.
- We were provided with evidence which demonstrated that action was taken based on incident trend analysis. However, we were not provided with a measurable action plan which would monitor and ensure improvement.
- During 2015 the hospital reported seven serious incidents, six of these related directly to surgery services.
- We reviewed the root cause analysis (RCAs) for all six of the surgery related serious incidents. These were comprehensively completed with lesson learnt and recommendations for improvement identified.
- There had been one serious incident in 2016 and again we noted this had been investigated and reported thoroughly.
- The majority of staff members spoken with during the inspection were able to describe improvements made following the completion of the RCAs. This included the amendment of a training package in one instance and the change to discharge paperwork in another.
- We saw exemplary practice in relation the management of incidents and subsequent learning points by the short stay suite manager. We saw that for the period of 2015 to the date of our inspection, this manager had

collated information on incidents relating to their area. For each incident, information was present which demonstrated how details had been fed back to staff, what action had been taken for improvement and how that improvement was being monitored to ensure effective implementation. This information was held in files accessible to all staff on the unit.

- Another area of exemplar practice shown by the hospital was the initiative to send feedback letters to incident reporters. We saw copies of these letters during our inspection and saw that the incident reporter was provided with feedback on how their incident had been handled and the outcome of any investigation.
- From our review of the hospital's 2015 clinical governance report we saw that the hospital had regard to duty of candour. Patients were contacted when things went wrong and provided with appropriate information and support.

Safety thermometer (Spire clinical scorecard)

- The Spire Cambridge Lea reported data on NHS orthopaedic patients to the NHS Safety Thermometer in four areas of avoidable patient harm; pressure ulcers, falls, urine infections and VTE incidents.
- There were no harms reported in the period between May 2015 and May 2016.
- Patient safety information was also reported and measured through the hospital's own clinical scorecard. Outcomes were reported and compared nationally against other Spire hospitals on a quarterly basis.
- Out of the 35 clinical scorecard outcomes, the hospital persistently failed to meet the target for seven in 2015. This included three patient satisfaction indicators, the incidence of hospital acquired VTE, surgical site infections in hip arthroplasty, the percentage of patients correctly fasted before surgery and the percentage of blood transfusions carried out where the pre-transfusion haemoglobin level was low. However, in 2016 improvement to the expected standard had been achieved in the incidence of hospital acquired VTE, surgical site infections in hip arthroplasty, the percentage of patients correctly fasted before surgery and the percentage of blood transfusions.
- There were seven cases of hospital acquired venous thromboembolism (VTE) during 2015. Four of these were pulmonary embolisms (PE) and three were deep vein thrombosis (DVT). Root cause analysis (RCAs) had been carried out in each of the PE incidents. Three were classed as unavoidable with one being identified as avoidable, meaning the hospital could have taken action which would have prevented the occurrence of the PE.
- There was one case of hospital acquired VTE in 2016 and the RCA demonstrated that this was unavoidable.
- Surgical site infection (SSI) data for 2015 showed that SSI rates for hip arthroplasty operations were slightly above the Spire national target. The hospital had made a 50% improvement from its 2014 position, and there had been 0% incidence in 2016.
- The 2015 incidence of SSI for total hip arthroplasty surgery was 0.65% and 0% for total knee arthroplasty surgery, against the Public Health England target of 0.6%. Regular monitoring of the SSI rate was taking place through the hospital's governance system. Thorough reviews had taken place into each identified case. No trends, such as them being acquired in a particular theatre, or after a particular medical team had been involved in the surgery, could be identified.
- The percentage of blood transfusions taking place where a patient's haemoglobin level was below 80g/l was a Spire set target. This hospital had not been meeting this internally set target due to clinicians working within their own clinical expectations and practice and undertaking haemoglobin levels during surgery and not prior. The hospital was working with the team to bring about changes. We noted that in quarter one 2016 compliance against this target had been met.
- The hospital had also not been meeting its target of patients correctly fasting prior to surgery for the whole of 2015. We noted that actions were being taken to improve this, which included the addition of information in pre-assessment documentation and instructions sent to patients. Quarterly monitoring was taking place to evaluate improvement. We noted form the quarter one 2016 clinical scorecard there had been a 20% improvement from the quarter four 2015 position.
- The hospital reported good performance in relation to VTE management scoring above its set target in 2015 for VTE risk assessment compliance, the prescribing and giving first dose of VTE chemo-prophylaxis and the correct medication course duration.
- The hospital also exceeded its target of 95% in 2015 for the completion of National Early Warning Scores (NEWS), taking and documenting of pain scores, and completing multi-disciplinary team (MDT) discussions for cancer patients.

- There were no incidents of pressure ulcers of grade two or above in 2015.
- There was low incidence of patient falls during 2015.
- Apart from the areas highlighted above, hospital performance in general was in line with Spire national averages.

Cleanliness, infection control and hygiene

- The hospital had up to date policies and procedures in place which were based on best practice guidance such as The Health and Social Care Act 2008 – Code of Practice on the prevention and control of infections and related guidance and the 2007 guidance Saving Lives – a delivery programme to reduce Healthcare Associated Infection.
- All areas visited were visibly clean and support staff were seen throughout the day undertaking cleaning tasks.
- We saw that cleaning checklists were completed for equipment, ward areas and patient rooms. We reviewed schedules from March 2016 and saw that these were complete, demonstrating that regular cleaning took place.
- Staff were aware of their responsibilities in relation to hand hygiene and using personal protective equipment (PPE). We did not see staff performing these infection control practices during our inspection due to all patients being nursed in single occupancy rooms. Sinks were only available in these rooms.
- However, hand sanitising gel dispensers were available and we saw staff utilise these.
- Hand wash sinks within the hospital were not compliant with Health Building Note (HBN) 00:09, Infection Control in the Built Environment. Sinks were not free from overflow and plug and they did not have mixer elbow operated taps. This had been risk assessed and short term mitigating actions were in place to deal with handwashing where an infection might be identified. This included the isolation of a patient room specifically for hand washing. Longer term plans were in place for sinks to be replaced when the ward undergoes refurbishment later in 2016.
- Hand hygiene audits were carried out by weighing hand gel to determine how much had been used within a specific timeframe. The infection control lead nurse had been undertaking local observation hand hygiene audits on a quarterly basis since January 2016 as part of the 'Saving Lives Care Bundle' audit. Spire Healthcare were implementing a national observational hand hygiene audit within the clinical scorecard measures from July 2016.
- We spoke with the infection control lead who provided a good overview of systems and process in place to manage infection control. This included the auditing of saving lives care bundles (sets of interventions that, when used together, improve patient outcomes), links to the NHS trust, escalation routes to the hospital management team and a proactive team.
- Each department had a nominated infection control link nurse who was responsible for providing updated guidance and information to their colleagues. They also met monthly with the hospital's infection control nurse to discuss local infection control issues and consider learning points.
- There was an infection control committee in place. This committee met on a quarterly basis and was supported by a consultant microbiologist from the local NHS trust.
- An annual infection control audit was carried out within the hospital and we saw that each department had developed an action plan to drive improvement following this audit. Action plans were regularly monitored.
- The hospital had effective procedures in place to screen for MRSA and methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia. At pre-assessment patients would be swabbed to test for the presence of these bacteraemia. Should MRSA or MSSA have been identified, patients were treated with anti-suppressant treatment before commencing their surgery.
- There were no cases of MRSA or MSSA in 2015. There was one case of MRSA in 2016. We noted that a thorough RCA investigation had been carried out which involved the local clinical commissioning group (CCG) and NHS trust. The outcome was that the source of the bacteraemia could not be identified. It was noted that the Spire Cambridge Lea had taken all necessary steps to care for the patient appropriately.
- There were no cases of Clostrium difficile (C.Diff) reported between January 2015 and the time of our inspection.
- Appropriate waste management systems were in place with the use of clinical and non-clinical waste bins and separate sharps disposal boxes. However, in theatres we saw inappropriate use of the clinical waste bin with general rubbish and recycling being disposed of.

Good

Surgery

Environment and equipment

- There were five theatres available for use at the hospital. Three of the theatres had laminar flow systems installed.
- We reviewed resuscitation equipment and associated checks from 1 May to 6 June 2016 on the inpatient ward and in theatres. Equipment was correct and had been checked daily.
- All areas were clean and tidy and corridors were free from clutter.
- Equipment such as portable suction machines, hoists and scales that were on the ward and the short stay suite were clean, regularly serviced and up to date to with portable appliance testing (PAT).
- Parts of the hospital were 29 years old and were tired in their fabric. We noted that a funding proposal had been submitted to the operations board of Spire Healthcare in May 2016 for extensive refurbishment throughout the hospital.
- However, in theatres, we found that equipment was not checked or used appropriately to protect staff or patients. For example, we saw a broken suction machine; it had a smashed regulator and no service or PAT testing date was displayed. A patient warming machine was also not labelled with service or testing dates.
- There was a broken socket which had not been marked for repair and electrical extension leads were used which posed a trip risk and an electrical risk from the potential spillage of fluids.
- X-ray gowns in theatres were not managed appropriately. Gowns were not numbered, there was no data available which demonstrated that they had been regularly checked and they were not stored correctly which meant damage could be caused to them.
- Theatre staff were also seen out of the department wearing theatre scrubs (no overcoat) and dirty shoes.
- These concerns were reported to management at soon as we identified them. During our unannounced inspection, two weeks after our announced inspection, we saw that the hospital had taken steps and achieved significant improvement. All broken equipment had been replaced. A new labelling and barcode system had been introduced for the use of x-ray gowns. Theatre staff had been provided with new overcoats for when they left the theatre environment.

Medicines

- There were up to date policies and procedures which were accessible to staff via the staff intranet.
- Medication was stored securely and appropriately in a locked drug room. The hospital used the NHS Protect medication security self-assessment to assure itself that all medicines were kept safely and securely.
- Procedures were in place which meant the hospital was compliant with controlled drug regulations. These medicines were kept in a lockable cupboard within the locked drug room. We reviewed the controlled drug logbook and saw this was completed accurately, with two members of nursing staff signing drugs in and out.
- Room temperatures were monitored and recorded daily. These remained within acceptable levels.
- The medication fridge temperatures, including those in theatres, were also monitored daily and remained within accepted levels.
- The hospital gave patients the choice to manage their own medications whilst staying in the hospital and we noted each patient room had a lockable medication cabinet.
- The hospital did not have piped oxygen. Oxygen cylinders were kept in designated “oxygen park” areas. We saw that these cylinders were checked on a daily basis.
- We noted excellent practice in the utilisation of the hospital pharmacist on ward rounds. We were told that the pharmacist would talk to patients about their medication and suggest possible changes, discuss individual patients with the resident medical officer (RMO) and provide general support to staff.
- Medication charts checked were legible and complete. Allergies, where identified, were clearly documented.
- There were 43 drug incidents reported in 2015 which was a significant rise from seven such incidents reported in 2014. This was attributed to a proactive pharmacist encouraging increased reporting. Twenty-six errors were attributed to nursing drug errors/omissions. We noted that a management plan had been put in place to support staff who had made these errors. In particular, one to one sessions and additional training had been provided.
- Regular medication audits took place, including controlled drug audits. We reviewed two audits from 2015 and saw actions for improvement had been identified. Feedback was provided to staff via team meetings.

- Medicines were appropriately managed in theatres. We checked the controlled drugs stock and saw this was managed appropriately.
- Following a concern raised with regards to the storage and access of IV fluids, where a member of staff was seen to rush from theatre because they did not have access to the required fluid from a locked cupboard, a new procedure was developed and implemented. This included a new code to the IV storage cupboard and strengthened directions on the safe storage of fluids.
- The pharmacy department had recently begun using the NHS Medication Safety Thermometer; a measurement tool for improvement that focuses on medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines. Data had only been collated for March and April 2016 so the tracking of trends and improvement could not yet be undertaken.

Records

- Records were easily accessible within a lockable cupboard opposite the nurses' station. We reviewed five sets of patient records during the inspection.
- Nursing records, including risk assessments, were completed in full as needed and plans of care were clearly documented.
- Pre-operative assessments were complete and accurate in all records reviewed.
- Consultant notes were generally present and legible within the patient record. However, in one case we found that consultant notes were not present following surgery and in another, consultant outpatient notes were not available. This meant there was potential important information may not have been available to other healthcare professionals or in the event of an emergency.
- Single patient records were not embedded within the hospital at the time of inspection. However, the majority of the records that we saw included notes from the entire patient pathway.
- The hospital was piloting a single patient record system with a view to holding a contemporaneous record for all patients. It was acknowledged that a dedicated space for records storage was needed and planning permission had been sought for the addition of buildings on site. This was an on-going project at the time of our inspection.
- In two of the three records seen, patient notes were left loose. This meant there was a risk that patient notes could be lost.
- In addition, each patient's record folder was kept in pigeonhole within the records cupboard and we saw that patient notes, which required filing, were being placed loosely into these pigeonholes. This again posed a risk that records may become lost.

Safeguarding

- The hospital had appropriate procedures to deal with safeguarding concerns. We saw that a localised procedure had been developed which provided staff with relevant internal and external contact numbers.
- Staff received regular safeguarding training. As at March 2016, 68.7% of staff had undertaken their annual safeguarding adults training and 62% had undertaken children's safeguarding training. This was against a quarterly target of 25%. One-hundred per cent of staff were due to be compliant by the end of 2016.
- Senior management, such as the matron and all clinical heads of department, were trained to level three safeguarding.
- All staff we spoke with were aware of their responsibilities to raise safeguarding concerns and provided examples of situations in which this might occur.
- From January 2015 to April 2016 no safeguarding concerns had been raised.

Mandatory training

- Staff we spoke with were aware of the requirement to complete mandatory training on an annual basis.
- In 2015, 96% of staff had completed their mandatory training. This met the hospital's mandatory training target of 95%.
- Ninety-five per cent of staff had completed information governance training in 2015.
- At the time of our inspection mandatory training compliance data provided stood at 88% for 2016. The hospital was confident it would meet the target for mandatory training completion by the end of the year.
- Mandatory training included fire safety, health and safety, infection control, safeguarding children, safeguarding adults, manual handling, compassion in practice, information governance and equality and diversity.

Good

Surgery

Assessing and responding to patient risk

- The World Health Organization (WHO) Five Steps to Safer Surgery checklist was in use at the hospital. We saw that these were present and complete in patient records. However, we observed the completion of a WHO checklist prior to the commencement of a surgical procedure and noted poor practice. We reviewed the completed checklist following the procedure and noted that boxes had been ticked to questions that had not been asked during the check.
- We raised this with the theatre manager who confirmed that recent auditing had identified the checklist in place was not appropriate to the hospital's requirements. A redesign of the checklist was needed. We saw evidence that this was being worked towards in the form of an action plan which included communication with other local hospitals in the area with a view to standardising paperwork.
- At the time of our unannounced inspection the hospital had introduced a new checklist which mirrored that of the local NHS trust. This had been well received by the surgical team and we saw that daily auditing of its completion was taking place. However, we could not test that this checklist had been embedded due to the infancy of its implementation.
- The hospital used the National Early Warning System (NEWS) to assess patient risk. NEWS is a nationally recognised scoring system to establish the stability and deterioration of a patient based on predetermined parameters for observations such as pulse, temperature, pain and blood sugar.
- We reviewed five sets of patient records and saw that NEWS were completed appropriately in accordance with best practice guidance.
- At the time of our inspection the hospital did not have facilities to care for patients requiring critical care. All patients requiring such care were being transferred to the local NHS trust.
- An Enhanced Recovery Area (ERA) was being set up to take up to two level one patients and was due to be open by the end of 2016.
- We spent some time in this area and saw outstanding planning and management in the set-up of this area. Clear, concise and accessible systems and procedures had been developed by the hospital's critical care lead. This included the monitoring of equipment, training of staff, the development of standard operating procedures and the development of local care standards in which the ERA would be performance monitored to ensure safe and effective care of patients.
- A local standard operating procedure (SOP) was in place which detailed how staff should escalate concerns about the deteriorating patient to the hospital medical team.
- In the event of patient deteriorating so significantly that they required more specialised care and treatment, there was a hospital transfer policy in place which dealt with the transfer of all critically ill patients.
- A service level agreement (SLA) was in place with the local NHS trust to receive critically ill patients. Staff we spoke with were well versed in the actions needed when transferring patients. We were told on more than one occasion that scenario based learning events had taken place which covered the transfer of a critically ill patient.
- In the event of a cardiac arrest there was a dedicated crash number for staff to call relevant members of the medical team. The cardiac arrest team was made up of the resident medical officer (RMO), theatre staff and senior nursing staff. Emergency call bells were available in each patient bedroom.
- Pre-operative assessments were completed either within the outpatient setting prior to admission or by patients completing a pre-assessment form at home. This was brought into hospital on the day of admission. This enabled the hospital to identify any potential risk factors which could impact the patient's treatment or recovery so that appropriate intervention could take place or be planned prior to their stay. All patients were assessed of their fitness for surgery using the American Society of Anaesthesiologists (ASA) physical status classification system.

Nursing and support staffing

- Staffing levels within the ward were calculated to meet patient dependency requirements using an adapted version of the Shelford Safer Nursing Care Tool.
- Patient dependency was assessed in advance of every shift by the nurse in charge to ensure the staffing levels were appropriate and safe. Staffing levels were increased or decreased in line with the dependency score.

Good

Surgery

- We reviewed completed daily dependency score sheets, retained by the ward manager, and found that dependency needs were correctly taken into account when establishing the staffing needs for the wards
- Staff flexibility was encouraged to enable flexing of the staffing rotas, resulting in staff being contacted to cover shifts where dependency had increased or be told that they were not needed when dependency had decreased.
- Staff spoken with confirmed that shifts were staffed in this way but that sometimes meant short notice for cover which did not promote a good work-life balance.
- The theatre department staffed each operating theatre within the required levels as recommended by the Association of Perioperative Practice (AfPP).
- The pharmacy was staffed by a pharmacy manager and two regular pharmacists. Bank pharmacists were used to cover holidays. The pharmacy also had one pharmacy technician and one pharmacy assistant.

Surgical staffing

- There were 231 doctors or dentists working at the hospital under practicing privileges.
- There was a resident medical officer (RMO) at the hospital 24 hours a day, seven days a week. The RMOs worked seven 24-hour shifts in a row, with facilities on site for them to sleep over night. RMOs were advised by their agency to inform them if they were disturbed frequently at night. An audit sheet was provided by the agency to monitor appropriateness of night disturbances. There had been no issues with night disturbance logged with the agency from RMOs based at the hospital.
- Individual consultants responsible for patients were contactable 24 hours a day whilst the patient was an inpatient. The RMO was aware of how to contact consultants.

Major incident awareness and training

- This hospital did not link into the local resilience and emergency planning arrangements.
- There were a number of business continuity plans, for flooding, loss of power and infection outbreaks. We were told that a drill session to test these plans had taken place early in 2016.

Are surgery services effective?

Good

Effective has been rated good for surgery services because:

- Policies and procedures were developed using relevant national best practice guidance.
- The hospital developed its own local procedures to support staff and promote effective patient care.
- Suitable arrangements were in place to manage patients' pain.
- Patients had access to appropriate nutrition and hydration.
- Patient outcomes were monitored in a variety of ways. This included the use of the hospital's clinical scorecard, the taking part in national audit, local audit arrangements and learning from national confidential enquiries.
- Staff were supported with learning and development to ensure they were competent in their role.

However:

- We were not provided with evidence which demonstrated the Royal College of Surgeons professional standards on consultation for cosmetic surgery had been audited to ensure compliance.

Evidence-based care and treatment

- Hospital policies and procedures were developed nationally by Spire and took account of relevant best practice guidance including that issued by the National Institute for Health and Care Excellence (NICE) and relevant royal colleges such as the Royal College of Nursing (RCN).
- Recently reviewed NICE Guidance at the hospital included NG46 Controlled drugs: safe use and management, NG45 routine preoperative tests for elective surgery and QS113 Healthcare-associated infections. We saw from minutes of the clinical effectiveness committee that revised policies and procedures had been developed based on this guidance. For example, in April 2016 the hospital's policy Clinical 14 - Policy for the Safe Management of Controlled Drugs was amended and notified to staff.
- We saw that updated polices and guidance were issued when there was a change in legislation or case law. For

example, we noted the hospital's Deprivation of Liberty Safeguards policy had been updated to reflect the Supreme Court's ruling in relation to applying the "acid test" in cases where a Deprivation of Liberty Safeguard was being considered. These updates and changes were notified to staff through the hospital's governance system.

Pain relief

- Patients' pain relief was prescribed immediately following surgery.
- This was monitored half hourly during the patient's recovery time and then hourly by nurse reviews as part of their care rounds on the ward.
- The pharmacist attended ward rounds and reviewed patients' levels of pain and medication where appropriate.
- Pain relief information was provided to patients on discharge and they were given details to contact the hospital should they feel their level of pain increased.
- A pain management group had recently been set up. We were told that the purpose of this group was to review the hospital's practice in relation to pain relief and discuss national learning and best practice.

Nutrition and hydration

- The hospital was supported by a dedicated on-site catering team.
- On admission people's dietary needs were assessed and the kitchen was informed as required. Staff told us that food could be provided according to the person's needs. For example, to take into account allergies or intolerances.
- Inpatients received three meals a day from a self-choose varied menu. Meals were also offered to relatives or carers who were staying with the patient.
- Water jugs were provided and were full in two of the patient rooms we checked.
- On the short stay suite we saw that patients, relatives and carers had access to tea and coffee making facilities. These facilities were also available in the reception areas of the hospital.
- Preoperatively patients were advised not to have fluids for two hours prior to surgery and solid food for six hours prior to surgery. Information on fasting was sent or given to patients during the preoperative assessment or consultation.
- The Spire Healthcare patient preoperative fasting target annual compliance score for 2015 was 41% against a target of 45%, although this had increased to 55% in the first three months of 2016. However, this meant a proportion of patients were at risk of not having the correct hydration prior to surgical procedures.
- To improve patient preoperative fasting compliance, actions had been implemented which included the introduction of a ward coordinator post, daily ward/theatre preparation meetings to confirm operating list order and the redesign of admission letters with fasting times identified.

Patient outcomes

- There were nine unplanned transfers of care at the hospital during 2015 and seven unplanned readmissions. This was within acceptable ranges given the size and complexity of the hospital.
- The hospital took account of relevant National Confidential Enquires into Patient Outcome and Death (NCEPODs). We saw the implementation of a sepsis screening tool following the outcome of an enquiry.
- PROMS data was collected for groin hernia surgery, total knee and hip replacements using the Oxford Hip and Knee score. Results were compared against Average Expected Health Gain and compared to all hospitals in the country, both independent and NHS. All results for this hospital were within range of the England average for NHS patients.
- The hospital took part in national audits for which it was eligible such as the National Blood Transfusion Audit and the National Joint Registry audit. Outcome data demonstrated that the hospital performed within expected levels.
- The hospital had a local audit plan. We saw evidence of local auditing in relation to records, medicines management and infection control and noted that action plans and the subsequent monitoring of those plans for improvement was undertaken. This was overseen by the clinical effectiveness committee.
- The hospital also monitored patient outcomes via the hospital's clinical scorecard, which has been reported on in detail under the safe domain in this report.
- However, we were not assured that the hospital had undertaken a review or audit to ensure it met the

standards issued by the Royal College of Surgeons professional standards on consultation for cosmetic surgery. This was because we asked to be provided with data which confirmed this and none was provided.

Competent staff

- There was a robust procedure in place for the granting and monitoring of practising privileges for consultants.
- All consultants practising at this hospital were required to submit a copy of their annual appraisal.
- There was an annual arrangement in place with the medical directors/responsible officer of the three local NHS trusts whereby the matron exchanged a spreadsheet with the medical directors confirming fitness to practice or otherwise for each consultant.
- Individual consultant dashboards relating to their practice at the hospital were provided annually to each consultant to support their annual appraisal.
- The hospital director and matron confirmed that a process was being implemented where consultants who have not practiced at the hospital for more that year would have their privileges suspended.
- Consultant revalidation dates were requested from each consultant in writing and evidence of GMC revalidation was required as part of ensuring they maintained practising privileges at the hospital.
- Appraisals had been completed for 100% of Spire staff in 2015.
- Appraisals were supported by individual learning plans. We spoke with staff who felt these plans supported learning and development. Staff told us that they were encouraged to undertake additional learning and were supported to pursue learning in areas of medicine which interested them.
- All staff received an induction prior to commencing work at the hospital.
- The hospital provided a variety of local training courses including dementia training, consent training and PREVENT (anti-terrorism) training.
- All staff were required to undertake annual basic life support training. As at March 2016, 43 %(against a target of 100%) of nursing staff had completed this training for 2016.
- At the time of our inspection eight staff members held advanced life support (ALS) training certificates. However, the operating department practitioners required a recertification of their ALS in order to be deemed competent. We were told this had been arranged, with places booked for July and August 2016.
- Enhanced Recovery Unit staff were undertaking step one of the National Competency Framework for Critical Care Nurses (NCFCCN) to ensure they had the right skills to care for patients who required enhanced recovery when this service was functional. Two members of staff had completed this training at the time of our inspection.

Multidisciplinary working

- Staff told us that staff from all services worked well together. We observed that there was a good rapport between staff and specialties.
- Pharmacists attended the daily patient ward rounds.
- There was an onsite physiotherapy service which provided input in people's care pre and post operatively.
- Following discharge we saw that paperwork was sent electronically to the patient's GP and this happened in a timely manner.

Seven-day services

- The resident medical officer (RMO) was available on site 24 hours a day, seven days a week and the ward were staffed 24 hours a day, seven days a week.
- The theatre team provided an out of hours on-call service when the department was closed.
- All consultants were contactable via their mobile phone or secretary throughout their patient stay.
- Consultant surgeons and consultant anaesthetists were required to provide the hospital with a default consultant colleague contact who would provide cross cover support if required.
- There was an onsite pharmacy open between 8am and 5pm Monday to Friday and 9am to midday on Saturday. The pharmacy was closed on Sundays and bank holidays. However, outside opening hours the RMO could access the pharmacy with a senior nurse.
- There was access to an on-site physiotherapist between 8am and 8pm on Monday to Friday and 8am to5pm on Saturday and Sunday.

Access to information

- Nursing and medical documentation was easily accessible. Staff we spoke with told us that when information was needed it was readily available.

Good

Surgery

- Test results, including x-rays, were held electronically. The consultants and RMO had access to these as required.
- Patients were provided with appropriate information to inform then about their stay in the hospital. This included a letter and a hospital leaflet.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Nursing staff we spoke with had a good understanding of consent and when consent was required.
- We reviewed five consent forms and saw these were completed in full and were legible. Risks and benefits were discussed with patients and clearly documented on the consent forms.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training compliance was low at 17%. However, this had increased to 70% at end of May 2016, following additional face to face training provided.
- However, we spoke with five members of staff who all demonstrated a good understanding of the requirements of the MCA and Deprivation of Liberty Safeguards. They were aware of the assessment criteria needed to assess if someone had capacity and understood that capacity could be fluctuating. Staff understood about the decision making processes for people lacking capacity to be in their best interests and knew who to contact should they need further support in relation to these procedures.
- During 2015 there had been no requirement for a MCA assessment or a Deprivation of Liberty Safeguards application to take place. This meant we could not test the application of the requirements surrounding these requirements.

Are surgery services caring?

Outstanding ☆

Caring was rated as outstanding for surgery services because:

- We heard directly from 30 patients who all reported overwhelmingly positive experiences. Patients felt the care received exceeded their expectations. Comments we received included "I couldn't have wished for better treatment" and "The staff and procedure were fault-less".
- Friends and Family Test data showed between 97% and 100% of patients would recommend the service.
- Feedback from patients and their relatives was continually positive and the hospital strived to achieve excellence in patient experience. Sixty-six per cent of patients already thought all aspects of the service were excellent and the hospital was working to improve feedback ratings of good or very good to excellent.
- There was a strong person-centred culture. People had their privacy and dignity maintained at all times and staff were compassionate to people's needs.
- Patients underwent a pre-assessment which took into account their holistic needs such as social, emotional and wellbeing. This meant that any adjustments needed to help support patients could be planned in advance of admission.
- Patients were provided with a discharge pack which provided information on how to find support and advice following treatment.
- Patients were active partners in their care; they were listened to and involved in decisions relating to their care and treatment. Patients' relatives were also involved and kept up to date when their loved ones were undergoing surgery.
- People's emotional needs were highly valued by staff and staff recognised the totality of people's needs. We were given examples of how these needs would be met. For example, staff working with patients to alleviate anxiety and going above and beyond to help support people after they left the hospital.

Compassionate Care

- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. We witnessed people being spoken to with respect at all times.
- We spoke with seven patients during our inspection and received 23 comment cards from patients undergoing treatment in the weeks preceding our inspection. Feedback was overwhelmingly positive.
- One patient told us "I have never had such fantastic treatment to be honest……it's absolutely outstanding" and another patient told us that the staff "couldn't have done enough" for them.

- Other comments included "the staff were really caring – I couldn't have wished for better treatment", "The staff were amazing, I couldn't have been more impressed with my stay"; and "I have been looked after with respect and consideration."
- We saw people's privacy and dignity was maintained at all times. Patient feedback provided through comment cards confirmed this with patients stating they felt their privacy and dignity had been preserved.
- The latest Friends and Family Test results (July 2015 to December 2015) were consistently above average, scoring between 97 and 100% of people recommending the hospital.
- The hospital's patient satisfaction survey from March 2016 demonstrated two thirds (66%) of patients felt the service was excellent in 19 tested areas, ranging from admission, the attitude of staff, the food, hospital cleanliness and discharge. On average, the remaining 33% of patients felt the service was very good (23%) or good (7%).
- The hospital was striving for excellence and had identified areas of patient satisfaction where it wanted to improve the excellent response rate. These had been identified on its clinical scorecard.
- We saw that the hospital's clinical scorecard results for 2015 showed that the target was narrowly missed (by 4%) for the percentage of patients responding "excellent" to the overall care and attention provided by nursing staff. The hospital wanted a response score of 85% but achieved 81%. However, the 19% of patients who did not respond excellent felt that on average the service was very good.
- Ninety-one per cent of patients felt that the care received by their consultant was excellent, with the remaining, on average, reporting this as very good. This met the hospital's target of 90%.
- The hospital was also monitoring the responses to how well patients were prepared for home. The hospital missed its target of 85% of patients responding excellent in 2015 by 9%. Again the majority of people who did not respond as excellent felt this was very good. We saw that action plans had been developed with ideas to achieve an overall excellent score. This included improving engagement with patients and reviewing discharge information and timeliness.

Understanding and involvement of patients and those close to them

- All patients we engaged with felt well informed and included in the entire decision making process in relation to their care and treatment. For example, one patient told us "All my questions have been answered" and the relative of a patient told us that they were supported by staff to accompany their loved one through treatment and recovery and aid in the care planning as they suffered from memory loss.
- A second relative told us "I was helped to find the coffee room and made to feel relaxed whilst waiting [for my relatives] procedure to take place. Staff showed me back to the recovery bay as soon as [my relative] was back."
- Another patient stated they had received "excellent care" and they had been "updated on all aspects of care and everything was explained well." A third patient commented, "everything was explained to me and I was involved in my plan of care including pain management."
- Patients confirmed that they had been given choice with regards to their treatment dates.
- Prior to admission to the hospital patient's underwent a pre-assessment where their holistic needs were assessed and taken into account. Areas assessed included people's social needs such as relationships, travel and hobbies and whether there were any needs in relation to mobilising, sleeping or eating. These assessments were reviewed by the hospital's pre-assessment team prior to the patient's stay so that adjustments, where necessary, could be made.
- Patients were given a variety of written information about the hospital and the care and treatment they would receive.
- On discharge from the wards patients were given a discharge pack. This included a booklet which explained the discharge process, the signs of urgent concerns following surgery with instructions to contact the hospital, advice about aftercare such as levels of activity, passing urine, pain control, bowel care, suture care and wound dressings.
- Inpatients had a named nurse and their nursing care was delivered and overseen by this nurse throughout their stay.

Emotional support

- Patients we engaged with told us staff were kind and considerate to them during their visit to the hospital. For

example, one patient stated that the staff "couldn't do enough to help me and calm me down as I was very anxious" and another patient told us "I was listened to and understood."

- A third patient commented the staff were "professional and extremely reassuring – I felt very relaxed" and a fourth patient stated they were extremely satisfied with the "empathy" shown by nursing staff.
- Staff we spoke with were aware of the emotional impact that a stay in hospital could have on patients. Staff gave us examples of how they would support patients which included making time to sit and talk with them, arranging for family members to be present as far as practicable, understanding religious needs and making provision to enable religious practices to be maintained during a patient's hospital stay. For example, a member of staff told us that, as there was no chapel on site, provision for prayer would be made by isolating a meeting room or patient bedroom for this purpose.
- We also heard of an occasion where a patient was highly anxious because they were afraid of not being able to eat food which had been specially prepared according to their religious beliefs whilst they were an inpatient at the hospital. We were told that staff worked with the patient and their family to alleviate this patient's anxiety. The hospital agreed to hire a freezer so that the patient's family could prepare food and have this available at the hospital for the patient.
- Another member of staff told us how they had gone above and beyond to find community support services for a patient. The patient involved did not have family and after their stay in hospital it was apparent that they would need further emotional and physical support; this member of staff personally liaised with the patient's GP in relation to their wellbeing and on-going support needs and identified services the patient could access on their discharge from hospital. The member of staff told us that they followed up on the outcome of the patient and offered on-going support.
- We also heard that on occasion where patients may run out of medicines at home and had no family or travel arrangements, members of the pharmacy team would arrange for these to be delivered.
- A chaperone service was available and information regarding how patients could access this was within each patient room.
- Staff would signpost patients to community support services that they could access on discharge if this was an identified need.

Are surgery services responsive?

Good

Responsive was rated as good for surgery services because:

- The service was planned and delivered to meet the needs of the patient groups it served.
- Access to the service was straightforward and timely.
- Patient flow was seamless and without delay.
- Systems and processes were in place to ensure patients' individual needs were met.
- There was evidence that learning from complaints took place.

Service planning and delivery to meet the needs of local people

- The Spire Cambridge Lea is a private hospital which provides surgical services including cosmetic surgery to self-funding or medically insured patients. Due to the private business set up, the hospital could provide flexibility and choice to patients choosing to undergo their treatment at the hospital.
- Information on the cost of treatment to patients was easily accessible. However, this had not always been the case. We noted that a series of complaints made with regards to unexpected charges had prompted the service to be more descriptive about potential treatment costs.
- The hospital received its NHS patient group through an NHS Standard Acute Contract with their local clinical commissioning groups and a number of local contracts with NHS trusts. The NHS contract terms ensured that the hospital made provision to cater for patients entitled to NHS standards of care.

Access and flow

- Patients had timely access to assessment, diagnosis and urgent treatment. There were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems.
- Patients were able to arrange their surgery at a convenient time for them.

Good

Surgery

- Surgery was predominantly elective and planned in advance; there were few instances of unplanned surgical interventions.
- Bed occupancy was low; this meant that patients had access to a bed as planned.
- Between January and December 2015 there had been seven re-admissions to the hospital, which was within expected ranges.
- Referral to treatment times (RTT) for NHS patients undergoing surgery was within the national expected timescale of 18 weeks for all patients.
- Following their initial consultation the hospital saw the majority of patients for pre-operative assessments. There were a few minor procedures which did not require a face-to-face pre-operative assessment. In these circumstances a paper assessment was required to be sent back to the hospital's pre-assessment team. This was then reviewed and should any concerns be highlighted we were assured that patients would be called in for an outpatient appointment prior to surgery.
- Appropriate discharge information was given which included contact details so patients could access help and advice where necessary.

Meeting people's individual needs

- The ward had been set up to meet the needs of individual patient groups. For example, we saw that patients requiring extra care and support were nursed next to the nurses' station and patients needing to mobilise following surgery were nursed in an area which had large corridors to assist with mobilisation and the use of equipment.
- Staff had access to translation services for patients who did not speak English or were hearing impaired.
- The ward was fitted with a hearing loop and staff received deaf awareness training. In addition, we were told that some staff had received basic sign language training to support patients.
- Staff had an understanding of the additional needs of patients living with dementia and learning difficulties, including additional monitoring. However, people living with dementia or learning difficulties were not routinely treated at this hospital.
- Equipment and support services, such access to a dietician, were available for bariatric patients.
- The hospital was compliant with the government's requirement to eliminate mixed-sex accommodation. Patients admitted to the hospital only shared facilities when clinically necessary such as in the extended recovery unit or in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity. The short stay suite had individual bays for patients with a curtain giving them privacy from the ward corridor. Patients in this ward shared toilet facilities which could be changed to male or female use depending on the patient mix on the unit.

Learning from complaints and concerns

- There was an accessible complaints procedure in place at the hospital, accessible to both staff and patients.
- Complaints were reviewed and discussed at the clinical effectiveness meeting and clinical governance committee meeting.
- Consultant specific complaints were discussed at the medical advisory committee.
- We noted that in 2015 63 complaints were received and were themed. This equated to 0.09% of the hospital's activity. The top three themes were communication, clinical care and hospital process. We saw that these were considered through the hospital's governance system and in order to make improvements during 2016 we saw that the key themes and lessons learnt were going to be presented to staff at mandatory training sessions.
- Following a complaint received regarding aspects of a patient's inpatient stay, the hospital had offered a face-to-face meeting with the patient. As a result of this, changes had been made to the discharge checklist completed by the nursing team. These changes were discussed and shown to the patient and as a result, further adaptions were made. The patient had been provided with an updated version of this document to allow reassurances that their feedback had directly influenced practice within the hospital.

Are surgery services well-led?

Good

Well-led has been rated good for surgery because:

Good

Surgery

- The hospital had a clear vision and set of values in place and staff were aware of these.
- The leadership team was proactive and looked for opportunities to improve patient care.
- There was an open door culture at the hospital and staff were encouraged and felt empowered to raise concerns.
- There was an effective governance structure and learning and improvement was evident.
- The hospital was supported by an active medical advisory committee.

However:

- Action planning was not always undertaken. This meant it was difficult to track and demonstrate improvement.
- Review dates had not been identified on the hospital's risk register so we could not be assured these were monitored or reviewed on a regular basis.

Vision and strategy for this this core service

- The national Spire vision was to be recognised as a world class healthcare business, bringing together the best people to develop the best clinical environments and deliver the highest quality care.
- The hospital's strategy was to become the "Hospital of Choice".
- There was a set of core values in place for staff to follow which included caring being a passion, succeeding together, driving excellence, doing the right thing, delivering on promises and keeping it simple.
- All of the staff we spoke with had an understanding of the goals and values of the hospital and how it had set out to achieve them.
- The management team shared with us actions being taken to meet the hospital's strategy, which included looking at recruitment and retention and developing staff.

Governance, risk management and quality measurement for this core service

- Governance processes were well established. This included a committee structure which considered the wider implication of processes such as incident management, audit, risk management and learning from complaints.
- Information flow between key committees was well documented, for example the MAC received regular reports from committees such as the clinical governance committee and the infection prevention control committee. All staff we spoke with were aware of issues and actions being taken to improve services. For example, in relation to patient experience.
- Medical advisory committee meetings took place on a quarterly basis and were well attended. Robust systems were in place to monitor the practice of consultants in this hospital and to monitor and challenge clinical practice.
- There was a clear focus on improving services based on learning and we were given many examples of this during our inspection and which have been reflected throughout this report. Particularly in relation to learning from incidents and complaints.
- We reviewed the risk register dated 12 April 2016 for the hospital and noted that risks were being identified and mitigated. There were separate risks identified for theatres and the wards. However, we could not be assured that these risks were being reviewed on a regular basis because review dates had not been identified.

Leadership / culture of service

- The hospital was managed by a dedicated and proactive leadership team which included the hospital director, the matron and medical advisory committee chair.
- Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff felt they could raise concerns without the fear or reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- Locally the service was supported by a team of dedicated and proactive managers who received a high amount of praise from the staff they managed. Each manager was fully versed in the challenges and areas of good practice in their individual areas and were committed to making positive change.

Public and staff engagement

- Patient opinion was gathered using patient surveys offered to all patients during their stay, Friends and Family Test and Patient Led Assessment of the Care Environment (PLACE) which was carried out annually.

Good

Surgery

- The hospital held patient forums which focused on the experiences and impressions of patients of the Spire Cambridge Lea Hospital. We were provided with a summary of the feedback provided at the last patient forum. Feedback received from patient forums was circulated to all clinical heads of department for departmental discussion and actions if necessary.
- Staff were engaged through weekly and monthly news bulletins that highlighted both departmental, hospital wide and national issues.
- There was a staff recognition scheme "Inspiring People" which gave staff the opportunity to be recognised and valued for their work.

Innovation, improvement and sustainability

- There was a strong local focus on staff development with a total of 45 staff members attending externally run courses throughout 2015.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Between January and December 2015 the outpatient department held 63,039 outpatient appointments, which consisted of both NHS and private consultations. These comprised of 45% (19,590) new appointments and 55% (43,449) follow-up appointments. NHS new and follow-up appointments represented 7% (4391/63,039) of outpatient work for 2015. Outpatient services saw both adult and paediatric patients, and paediatric patients represented 4% of outpatient work within the reporting period. This amounted to 1018 new appointments and 1379 follow-up appointments.

The hospital offered a wide range of diagnostic services, including fixed site magnetic resonance imaging (MRI), computerised tomography (CT), an ultrasound room, digital mammography, theatre imaging, panoramic dental x-ray scanning of the upper and lower jaw (orthopantamogram) and general x-ray. Outsourced services included Dexa scanning to measure bone mineral density, MRI hire when the hospital's own equipment is being serviced, some pathology services and supply of resident medical officers (RMO). In 2014, the hospital underwent development which included a redesigned outpatient reception and the refurbishment of the 22 consulting rooms. There were also three dedicated treatment rooms and a hearing test booth.

During the inspection, we visited outpatient clinics and treatment areas. We spoke with 15 patients, families or carers about their experiences at the hospital. We spoke with 21 members of staff regarding their work and the hospital in general. We reviewed documentation in relation to the general running of the services, maintenance of equipment and buildings; we also reviewed 10 patient records and reviewed information provided to us prior to and during inspection.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient and diagnostic imaging services as good overall.

Safe, caring, responsive and well-led were rated as good. We currently inspect but do not rate the effective domain for outpatient and diagnostic imaging services.

Patient safety incidents were reported and investigated appropriately and feedback was provided to the reporter. There had been no hospital acquired infections in 2015, and the service had robust methods in place to share information internally within the hospital.

Patients had access to medical care 24 hours a day, seven days a week, either in outpatient clinic times or via the resident medical officer. There were systems in place for clinical staff to securely access patient tests and imaging results. Patients had access to a consultant led pain clinic

Patients spoke very highly of the care they received; their feedback was listened to and acted upon by the service. Specialist nurses and sensory distractions were used to improve patients' experience, and link nurses were used to cascade and escalate information to and from committee meetings. Access to services was straightforward and timely, with 95% of patients being seen either before or at the time of their appointment. For the 5% who were not seen on time, there was an agreed procedure in place to keep patients informed of expected time delays. We saw that learning from complaints took place and practice had changed as a result to make improvements.

There was a clear hospital vision and set of values which staff were aware of, and aligned to their work. Staff were able to raise concerns, which in turn would be escalated to the clinical governance committee. The hospital was supported by an active medical advisory committee which regularly monitored consultants' fitness to practice. Patients we spoke with felt able to raise any concerns they had with their consultants.

A single patient record was not embedded through the hospital. However, a single patient record pilot had been implemented in April 2016.

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatient and diagnostic imaging services as good for safe because;

- Incidents were reported and investigated appropriately, and feedback was provided to individual reporters.
- There were small numbers of incidents that had required duty of candour provision for patients, but staff we spoke with knew when this would be appropriate and the process for providing it.
- There had been no hospital acquired infections reported within 2015.
- Infection prevention issues and concerns were effectively managed via departmental link members of staff, who shared information appropriately.
- At the time of inspection we were concerned that children's resuscitation equipment was not receiving daily checks. This was raised at the time and systems were put in place to ensure daily monitoring.
- Protective equipment was used to maintain safety in diagnostic imaging and regular monitoring audits were completed

Incidents

- The hospital had an incident and near miss policy which encouraged staff to report all incidents regardless of outcome. Incidents were discussed within clinical governance and senior team meetings.
- Learning from serious incidents was shared within the hospital to benefit patient safety. Incident data was regularly discussed in directorate and clinical effectiveness meetings. For example, a patient was provided with a controlled drug for pain relief as a take home medication without a second signature, which was against hospital policy. This was highlighted in the medication safety report and an incident investigation was being completed by the hospital.
- Staff told us that if they reported a clinical incident on the electronic reporting system, they would receive feedback on the investigation and any outcomes or actions following it.

Good

Outpatients and diagnostic imaging

- No never events (serious incidents that are wholly preventable) had been reported from March 2015 to March 2016 in outpatients and diagnostic imaging.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including the Care Quality Commission (CQC).
- There was one IR(ME)R reportable incident between March 2015 to January 2016 in relation to a patient rescan as they were not originally given enough contrast to provide clear diagnostic images, resulting in the patient having to have a repeat scan which increased their exposure to radiation. This was reported appropriately in line with protocol, and standard operating procedures were created to minimise the risk of reoccurrence.
- In July 2015 the hospital had reviewed and amended its duty of candour (duty of candour is a legal duty on hospitals, to inform and apologise to patients if there have been mistakes in their care that have led to significant harm) policy for staff, to incorporate the General Medical Council and Nursing and Midwifery Council's joint guidance, to encourage a culture of openness and honesty within healthcare professions when things go wrong. Staff we spoke with were able to give examples of where duty of candour would be appropriate, and how they would provide this to the patient.

Cleanliness, infection control and hygiene

- The areas visited during inspection were visibly clean and tidy. Nursing staff completed cleaning schedule checklists, which were up to date for 1,2,3 and 6 June 2016 at the time of inspection.
- Outpatients had not had any instances of patients having hospital acquired infections such as Clostridium difficile **(**C-Diff), Methicillin Sensitive Staphylococcus Aureus (MSSA), or MRSA.
- We observed outpatient staff using hand gel as they entered consultation rooms for infection prevention purposes.
- Appropriate waste management systems were in place with the use of clinical and non-clinical waste bins and separate sharps disposal boxes.

Environment and equipment

- We saw a maintenance log which showed that outpatient and diagnostic imaging equipment was regularly checked and were serviced appropriately.
- The hospital had an engineering team on site that provided cover between 8am to 5pm Monday to Friday. Outside of these hours there was an on-call system.
- Regular generator and fire alarm tests were conducted by the internal engineering team and there were annual external contractor reviews for fire alarms.
- Electrical equipment in treatment and consultation rooms was regularly monitored and serviced by engineers.
- The children's resuscitation trolley had not received daily checks for the month of March 2016. We raised this with the resuscitation lead at the time of inspection. We returned for an unannounced inspection on 20 June 2016 and found that the children's resuscitation trolley was receiving daily checks.
- We reviewed the adult resuscitation trolley. Checks had been completed from 3 March 2016 to 6 June 2016
- Results of hospital-wide audits, for example the Patient Led Assessment of the Care Environment audit, were displayed in the outpatient waiting area, so that patients and relatives could access this audit information and see actions completed to improve the patient environment. The hospital scores ranged from 100% for cleanliness, to 84% for privacy, dignity and well-being within the 2016 audit.
- A mammography quality assurance audit dated July 2015 demonstrated that the equipment was safe and no patient safety concerns were raised.
- The x-ray department monitored levels of radiation exposure in the department to ensure that radiation levels were safe.
- Radiology staff were required to use lead aprons to protect themselves against unintended radiation exposure. Lead aprons were in good condition and were checked on a regular basis and replaced when not fit for purpose.
- Radiology staff all carried film badge dosimeters whilst working clinically which registered the amount of personal radiation exposure they had been subjected to and these were reviewed regularly to ensure staff safety. There was a local audit plan for imaging. This included a number of audits to ensure that the equipment and environment was safe for patients, for example the World Health Organisation's checklist, lead aprons, and x-ray markers.

Good

Outpatients and diagnostic imaging

Medicines

- Medication was stored securely and appropriately in locked drug rooms.
- Contrast media was kept in a locked wall mounted cabinet in the imaging room. The keys to this cupboard were only accessible to radiologists, radiographers, consultants or managers.
- Allergies were clearly documented in patient pathway documents.
- June 2016 fridge temperatures were checked daily and all were found to be recorded and within range, meaning that medications were stored appropriately
- Diagnostic imaging had six Patient Group Directions (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients) for the administration of commonly used medication including saline and contrast media. These PGDs sped up provision of service to the patient who would otherwise have had to wait for a specific prescription to be written and processed.
- Radiology staff used a heating cupboard to ensure that the daily calculated amounts of contrast media to be used for patients was warmed to human body temperature prior to administration. This made the process more comfortable for the patient.

Records

- We reviewed 10 sets of notes and found that referral letters and medical notes were not kept with the patient pathway documentation but were retained by the consultant in line with accepted practice within the independent sector. All information was available on request and throughout the patient journey.
- The 10 sets reviewed were for patients who had been treated at an earlier date to the inspection and were not being treated on the day of inspection. All reviewed were legible and dated, however one was unsigned by a clinician.
- Full and contemporaneous notes were available when a patient attended in the outpatient environment, which included the patient referral letter, clinic consultation letters (both held and brought to clinic by the consultant) and the patient care pathway if they undergo an invasive procedure (completed by the attending nurse and consultant at the time of treatment). Although they are not held within the same folder they are all available whenever the patient is onsite.
- Between the months of October 2015 to March 2016 the hospital met its target of 90% of consultants completing patient record entries by signing and dating each entry.

Safeguarding

- From January 2015 to April 2016 no safeguarding concerns had been raised.
- At the time of inspection the children's outpatient services were in the process of ceasing. However, there was a registered nurse (child branch) available.
- Children's and young people's safeguarding consisted of three levels. Level one was provided for any member of staff who would have contact with children (including administrative staff). Level two was for staff who would have some level of interaction with children, but would not be directly involved in planning their care. Level three was for staff members who would be directly involved in children and young people's care and responsible for planning treatment and care plans. In March 2016, 69% of staff had undertaken their annual safeguarding adults training and 62% had undertaken children's level two safeguarding, which was above the trajectory of 25%.
- The hospital lead for safeguarding children and adults was the matron, who was trained to level three. Matron was supported by the outpatient manager for both children and adults, the registered nurse (child branch) and the paediatric physiotherapy lead, who were trained to level three children's and young people's safeguarding.

Mandatory training

- Mandatory training was provided by a combination of e-learning and face-to-face training sessions. The hospital had a target of 95% completion of mandatory training on an annual basis for its staff. This was made up of rolling trajectories of 25% each three months. Life support training was not included in the trajectory, but on an annual basis.
- Mandatory training was made up of nine modules; adult and child safeguarding, equality and diversity, manual handling, fire safety, compassion in practice, health and safety, information governance and infection control.

Good

Outpatients and diagnostic imaging

- Data from the clinical scorecards showed that between October to December 2015 96% of staff across the hospital had completed mandatory training, which exceeded the target.
- Data from March 2016 showed staff completion was 62% to 97% for each of the nine mandatory training modules, which exceeded the rolling target of 25%.
- Between January and March 2016 43% of nurses and health care assistants had completed their basic adult life support mandatory training. All staff were required to complete this training by December 2016.
- Between January and March 2016 25% of radiographers and 15% of non-clinical administrative staff had completed adult life support training.
- Between January to March 2016 41% of nurses and 34% of health care assistants had completed paediatric basic life support (PBLS) training.
- Two nurses were paediatric immediate life support (PILS) trained, and three nurses and the resident medical officer were emergency paediatric life support (EPLS) trained.

Assessing and responding to patient risk

- If a patient within the outpatient or diagnostic imaging areas was deteriorating whilst attending clinic, the resident medical officer was available to review them in an emergency.
- The hospital had a service level agreement in place with local NHS trusts to support the transfer of deteriorating patients into NHS care.
- The hospital used the National Early Warning Score (NEWS) to record patients' observations such as blood pressure, pulse and temperature. If observations were outside a normal range medical review would be sought.

Nursing staffing

- The outpatient department's senior nursing staff would assess clinic schedules on a weekly basis to ensure that sufficient staff were on duty to safely manage outpatient and diagnostic imaging clinic lists.
- The outpatient department was staffed by 14 registered nurses, four health care assistants and four members of long-term bank staff who had received the same hospital induction as substantive members of staff. Bank members of staff were used to cover holidays and sickness cover where this could not be flexibly covered by other staff members.
- The March 2016 rota showed that bank staff provided 44 hours of nursing cover in a week.
- There were no radiographer vacancies within the reporting period of January to December 2015, and staff told us that one long-term bank radiographer was used to support staff taking annual leave within the hospital.
- The diagnostic imaging department used overtime to cover radiographer gaps in rotas, with a bank radiographer to cover annual leave. One radiographer post had recently been recruited to

Medical staffing

- There was a 24-hour resident medical officer (RMO) on site.
- All consultants were contactable throughout the patient stay if needed. Consultant surgeons and consultant anaesthetists were requested to provide the hospital with a default consultant colleague contact who would provide cross cover support if required.
- The hospital employed two radiation protection supervisors (RPS), and had formal links with a radiation protection advisor (RPA) from the local NHS trust (under a service level agreement). The hospital's RPS's were based on-site Monday to Friday 8.30am to 5pm. This met the requirements of the Health and Safety Executive's (HSE) statement on radiation protection advisors.
- The hospital employed seven radiographers who each worked three 12.5 hour days per week, to cover consultant requirements for clinics.

Major incident awareness and training

- Hospital staff received scenario based training sessions in preparation for a patient cardiac arrest/collapse, 10 of these sessions were held each year. At the time of inspection, four of these scenarios had taken place; two were ward based, one was stairwell based and the other was a physiotherapy based scenario.
- Additional fire evacuation training was regularly provided and ensured that staff knew how to move patients out of the building, including the use of patient moving equipment such as stair evacuation chairs in the event of an emergency. Diagnostic imaging staff told us that there was a contingency plan in place in preparation for a major incident.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

We do not currently rate the effective domain for outpatients and diagnostic imaging services, but we found that;

- Staff were supported with learning and development and demonstrated competence in their roles.
- Staff could access corporate and local policies.
- Managers involved staff in clinical audits to review and improve services offered to patients.
- Patient outcomes were monitored in a variety of ways. This included the use of the hospital's clinical scorecard and local clinical audits.
- One-hundred per cent of nursing staff in outpatients had completed their annual appraisals in 2015.
- A consultant-led pain clinic was available for patients to access within the outpatient department.
- Patients had access to appropriate nutrition and hydration.
- Link members of staff provided strong links with committees such as infection control and health and safety.
- We observed good working relationships between staff and departments.
- Patients had access to medical care 24 hours a day, seven days a week.
- There were systems for accessing patient notes, test results and imaging.
- Specialist paediatric and breast care nurses were available to support patients, relatives, and carers.

Evidence-based care and treatment

- Staff had access to policies in hard copy and on the staff intranet. Policies were based on national guidance, for example National Institute of Health and Care Excellence (NICE). We saw an example of a policy for infection prevention and control which was in date and referenced a 2013 NICE quality statement about surgical site infections.
- Policies were regularly reviewed to ensure that they were aligned to best practice guidance.
- Staff received details of patient safety and medical device alerts via clinical effectiveness and clinical governance meeting papers. Managers confirmed if alerts were relevant to them, they were monitored and details minuted in clinical governance meetings. We saw an example of a medical device alert in the January 2016 clinical governance minutes relating to home blood glucose monitoring systems, as there was a risk that these may not be accurate. The outcome was that only hospital devices were to be used which had been regularly calibrated for accuracy of results.
- The risk register was linked to national guidelines, for example the Ionising Radiation (Medical Exposure) Regulations 2000. Quality assurance audits to show that diagnostic imaging were following these national guidelines were regularly completed for patient safety, and results were included in the radiation protection advisor's annual safety report.

Pain relief

- A consultant-led pain clinic was provided in the outpatient department. Three consultants covered one and a half days a week in half day sessions. This was in line with national best practice.
- Between nine and 25 patients attended each of the half day pain clinic session in the months of April and May 2016.
- Topical anaesthetic cream, which was normally used for children, was used for adults who were either anxious about receiving treatment, or had known needle phobias.

Patient outcomes

- There were a number of local audits planned for outpatient and diagnostics. These included auditing of consent, discharge letters and procedure of sharps counts in minor operations.
- Local audit results were discussed in department team meetings.
- The diagnostic imaging manager kept a hard copy folder of audits available for staff to review, and told us that staff were actively encouraged to feed ideas in for local audits.

Competent staff

- All members of staff received an induction prior to starting work in the hospital, which covered staff's mandatory training requirements.
- All consultants employed by NHS trusts provided the hospital with a copy of their annual appraisal. There was also an annual arrangement in place with the medical

directors/responsible officers of the three local NHS trusts where matron exchanged a spreadsheet with the NHS trust's medical directors confirming individual consultant's fitness to practice.
- Individual consultant dashboards relating to their practice at the hospital were provided annually to each consultant to support their annual appraisal.
- Consultant revalidation dates were requested from each consultant in writing and evidence of General Medical Council (GMC) revalidation was required to ensure they maintained their rights to work at the hospital (practising privileges).
- There was funding available for external training. Staff went on training suited to their individual needs. Staff gave examples of training they had been on including courses in marketing, first aid and information technology (IT).
- Information about nurse revalidation was available on the staff intranet and was discussed within the April 2016 clinical governance meeting. Nursing revalidation in outpatients was managed by the outpatient manager.
- Nursing and administrative staff said that they took part in monthly one-to-one meetings with their manager in a supervisory capacity and reported feeling supported by managers.
- In the outpatient department, 100% of nursing staff and care assistants had an appraisal between January 2015 and December 2015. Staff knew about the appraisal process and gave us examples of their objectives.
- Radiographers were available to support radiologists and completed competency assessments for general procedures as well as specialist specific competencies such as for ear, nose and throat or gynaecological procedures.

Multidisciplinary working (related to this core service)

- Outpatient and diagnostic imaging services had breast care specialist nurses and sick children's specialist nurses who worked across staff teams to provide specialist advice to both staff and patients.
- Staff told us they had regular team meetings. Minutes from these meetings were available on the staff intranet.
- Nominated link staff went to committee meetings on health and safety and infection control. They communicated relevant information to staff in the department and took areas for escalation back to the committees.
- Staff said that communication in the outpatient and diagnostic imaging departments was good. For example, the appointments lead met with individual consultants to help understand their needs.
- A consultant in outpatients told us that communication between consultants and nursing staff was good. The outpatient nursing team developed a nurse coordinator role in response to feedback from consultants that nursing staff were not visible in the department.

Seven-day services

- Outpatient services were available between 8am to 9pm Monday to Thursdays, 8am to 7pm on Fridays, and 8am to 2pm on Saturdays.
- There was an onsite pharmacy open between 8am to 5pm Monday to Friday and 9am to 12pm on Saturdays. Outside of pharmacy opening hours the resident medical officer could access the pharmacy with a senior nurse.
- Diagnostic imaging services were available from Monday to Friday between 8.30am and 5pm with alternate Saturday mornings. Radiography staff worked flexibly to provide radiography cover as required by outpatient consultants during the week.
- Radiographers worked until 9pm to support consultants running evening outpatient clinics. This meant that patients could have their outpatient appointment and scan completed within one visit.
- Magnetic resonance imaging (MRI) clinics were held between the hours of 7.30am to 7pm and the diagnostic imaging manager was able to provide additional cover for this specialist area as and when required.
- There was an on-call system in the imaging department. This meant that consultants or the resident medical officer (RMO) could ask for urgent plain film x-rays outside of normal working hours.

Access to information

- Staff could access scans and imaging reports using secure electronic systems such as the picture archiving and communication system, the radiology information system and the image exchange portal from other providers.
- Medical records were kept on site for three months. After this, they went to a central store. Staff could get records

Good

Outpatients and diagnostic imaging

from the central store within 24 hours. The clinical staff we spoke to confirmed that they could get medical records in good time and they knew the process for doing this.
- There was a tracking system in place to stop records from going missing.
- There was a secure process for sending information via email, both internally and outside of the organisation. This was achieved by using an encryption service.
- Staff could access policies and procedures through the intranet.
- Reference information was displayed in staff areas and patient waiting areas. We saw information on emergency protocols, fire safety procedures, identification photographs of staff and an equipment log in the staff areas of the imaging department.
- In the outpatient waiting area, we saw information including audit results and patient feedback comments. Following patient discharge we saw, from patient records, discharge summaries were sent electronically to the patient's GP. This meant information about the person's care and treatment was accessible to other health professionals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment forms were completed and logged in patient records. We saw four examples for minor operations and surgery consent forms, which were completed appropriately.
- In outpatients, managers and senior nursing staff members could describe how mental capacity was checked and could identify when it would be appropriate to test a patient's capacity.
- Mental Capacity Act and Deprivation of Liberty Safeguards training was provided both electronically and in classroom situations. Between October 2015 and December 2015 a member of the local county council specialising in Mental Capacity Act training provided eight sessions for staff to attend and learn about the theory and practical elements of the MCA and Deprivation of Liberty Safeguards.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training compliance was 70% at end of May 2016.
- Ninety-seven per cent of staff had completed dementia training via Spire's e-learning programme, which exceeded Spire's target of 95% in 2015. In addition, local face to face dementia training for clinical staff and 'Dementia Friends' training for non-clinical staff was provided by Alzheimer's UK representatives in April 2016.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatient and diagnostic imaging services as good for caring because;

- Staff received 'compassion for patients' training as part of their mandatory training.
- Patients we spoke with spoke very highly of the quality and professionalism of care they received.
- There was an open culture and patients we spoke with told us they felt able to ask consultants questions and able to raise any concerns they had.
- Patients and relatives felt informed about future procedures. Information was supplied to patients ahead of their treatment.
- Sensory distractions were used to alleviate anxiety levels of patients using magnetic resonance imaging scanning equipment within diagnostic imaging.
- Specialist nurses were available to support patients and relatives attending the hospital for consultations.

Compassionate care

- Compassion in practice was an electronic local mandatory training course for staff. At the end of March 2016, 97% of staff had completed this.
- Patient feedback we received was generally very positive. Comments received included; "Staff friendly, caring. No problems. Waiting times not bad."
- We spoke to a patient with a young baby who told us services were brilliant for children. They told us that it was good that toys were available. The patient told us staff had been "really accommodating". They had found the hospital really good overall, and had no complaints.
- Diagnostic imaging staff told us about a recent incident of a fainting patient in the main reception area, and they described how screens had promptly been supplied to protect the patient's privacy and dignity.

Understanding and involvement of patients and those close to them

Good

Outpatients and diagnostic imaging

- Patients we spoke with advised that they felt able to ask questions if not sure and raise concerns.
- Patients reported receiving information about their procedures with their appointment details in the post prior to receiving treatment.
- Patients said that consultants were excellent and gave them detailed medical explanations.

Emotional support

- The hospital employed a registered nurse (child branch) to support paediatric patients and their families or carers.
- Diagnostic imaging staff provided sensory distractions such as music, dvd and mood lighting for anxious patients undergoing magnetic resonance imaging scans.
- Specialist breast care nurses were employed within diagnostic imaging to support mammography patients to regain confidence as part of their recovery.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatient and diagnostic imaging services as good for responsive because;

- Between January and March 2016, 95% of outpatients were either seen at or prior to their appointment time, with just 5% being seen after their booked appointment time.
- Nursing staff informed patients of anticipated delays at initial book in at reception or once they had been waiting for more than 15 minutes.
- There was monitoring and follow-up of patients not attending clinic.
- There was evidence that learning from complaints took place.
- Patient survey feedback was positively responded to within the diagnostic imaging department.

Service planning and delivery to meet the needs of local people

- All outpatient and diagnostic imaging referral to treatment times had been met between January to December 2015.
- There were specialist outpatient clinics running that included audiology, gynaecology, orthopaedics, paediatrics, and cosmetic surgery.
- The main outpatients department ran clinics into the evenings to enable patients to attend the clinic outside of working and school local hours.

Access and flow

- There were processes for booking NHS and privately funded patients into the hospital either via the booking team located within the hospital or via the consultant's secretaries.
- The hospital had an NHS Standard Acute Contract with their local clinical commissioning groups and a number of local contracts with NHS trusts. NHS patients were referred to the hospital via the electronic referral system. Five specialities were using this system; ears nose and throat (ENT), ophthalmic, orthopaedic, urology and general surgery. Referrals were reviewed daily by the bookings team and patients were allocated an appointment. All patients were seen within 18 weeks of referral.
- Monthly monitoring of patient waiting times for clinics was recorded. Between January and June 2016, 95% (39/41) of patients were seen before or within their booked appointment time.
- Patients we spoke with told us that generally they did not have to wait for more than five to 10 minutes once they had arrived to go into their appointment.
- Between January 2016 and May 2016, outpatient 'did not attend' (DNA) monthly rates for patients was three to five per cent (143/4571). The hospital had a tracking system in place to monitor this, and all non-attended appointments were followed up to ensure patient safety.
- The physiotherapy service was trialling a text messaging service to remind patients of their appointments. If this was successful, the plan was to use this system across the hospital to remind patients of future appointments.
- If clinics were running late, after 15 minutes, reception staff would contact the consultant and keep waiting patients informed.
- We observed reception staff keeping patients informed by letting them know at check-in that clinics were over-running.

Good

Outpatients and diagnostic imaging

- Booking leads made cancellation lists for clinics which were exceptionally busy, for example ear nose and throat, to enable patients to be seen as soon as possible.

Meeting people's individual needs

- We asked nursing staff how the needs of patients with learning disabilities or patients living with dementia would be met by the department. Staff confirmed that outpatients saw very small numbers of these patients, but reasonable adjustments in terms of extended appointment times and allowing relatives to attend consultations appointments were made.
- Young people aged 16 and 17 years old were individually risk assessed and treated on an inpatient adult care pathway if deemed appropriate.
- The hospital had disabled parking available close to the hospital entrance. The outpatient's reception desk had a lowered area for ease of wheelchair access, and there was adequate room to enable wheelchairs to negotiate access to disabled toilet facilities and around the hospital using lifts for access to the first floor ward areas.
- An induction loop was available to support patients with hearing difficulties.
- Staff had access to translation services for patients.
- Following patient survey feedback received between February to April 2016, 75% of diagnostic imaging patients said they had received adequate information before their procedures. In response to this staff had created information leaflets and results of future surveys would monitor effectiveness.
- Patients were provided with appropriate information to inform them about their hospital visit, including a hospital letter and any relevant patient information leaflets.

Learning from complaints and concerns

- Five outpatient and diagnostic imaging patient complaints received by the hospital between December 2015 and May 2016 were about unexplained costs of blood tests, photography, ear, nose and throat (ENT), consultant and x-ray procedures; this resulted in a financial information form being developed outlining costs. Patients read and signed this before their treatment.
- Complaints were discussed at clinical effectiveness, medical advisory committee and clinical governance meetings. We reviewed minutes of the clinical effectiveness meeting dated 18 April 2016 and saw that meeting attendees were presented with the complaints log detailing complaints received in the previous month, and actions taken as a result.
- The hospital had developed a leaflet listing all costs of diagnostic tests, following concerns that patients were not aware of costs if additional test were required during their outpatient consultation.
- There was a complaints procedure in place at the hospital to inform staff how to support patients wishing to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated outpatient and diagnostic imaging services as good because;

- The hospital had a clear vision and set of values in place and staff were aware of these.
- There were mechanisms in place to report clinical concerns via the clinical governance committee, which were then acted upon by senior managers. The hospital was supported by an active medical advisory committee.
- There was a process in place for monitoring consultants' practising privileges.
- Patients' views and feedback was sought through audit and surveys.

Vision and strategy for this this core service

- There were a set of core values in place for staff to follow, which included caring being a passion, succeeding together, driving excellence, doing the right thing, delivering on promises and keeping it simple. Staff we spoke to were aware of the values.
- The hospital's five strategic objectives for 2016 were to deliver high quality patient focused care, to be the 'hospital of choice' for staff, patients and consultants, to provide care for patients from the start to the end of their care pathway, to continue to focus on staff engagement, and for hospital facilities to meet the demands of the services provided.

- Heads of department were responsible for cascading the 2016 vision to staff, and staff we spoke with were aware of the key objectives.

Governance, risk management and quality measurement for this core service

- The hospital had introduced a hospital risk register in January 2016.We reviewed four risks in imaging and four risks in outpatients. All had adequate controls in place, identified owner and rated according to likelihood of occurrence. However, action review dates were not completed, so we were not assured that reviews of risk were taking place.
- Each month a log of new National Institute of Clinical Excellence (NICE) guidelines was shared with the hospital by the central clinical governance team. The hospital completed monthly and quarterly review of NICE guidance at the clinical effectiveness committee and clinical governance committee meetings respectively. Any identified relevant and applicable guidance was circulated to the relevant heads of department for discussion in departmental meetings and changes to practice/policy are made. Spire Healthcare also updated national policies with reference to updated NICE guidance.
- At the time of inspection the role of governance and compliance manager was vacant. However, the position had been recruited to, and in the interim the matron was overseeing governance functions.
- Medical advisory committee (MAC) meetings took place on a quarterly basis and were well attended. We reviewed four sets of MAC minutes, which were comprehensive and covered a wide range of issues such as regulatory compliance inspections (radiation protection survey for radiology services), review of appointment letters in outpatients, duty of candour, active risk register entries and practising privileges of consultants.
- We saw evidence of ongoing monitoring of risk assessments forming part of the 'risk library' completed and reviewed within diagnostic imaging to ensure that the environment was safe for treating patients. For example, the acoustic noise of the magnetic resonance imaging scanner and risk of harm occurring to visiting children in the x-ray department.

Leadership / culture of service

- If staff witnessed something of concern which they did not feel confident raising personally, there was a whistleblowing policy which supported staff to raise concerns anonymously.
- Staff members attending the focus group told us that staff and managers were supportive to staff's personal circumstances and would attempt to support staff, for example if a shift required rearranging.
- Staff told us about 'Inspiring people' awards which were given to staff by the senior management team.
- We observed outpatient team awards displayed in the patient waiting area. For example, 'Reception and Outpatient Nurses team of the year 2014'.
- Diagnostic imaging staff had been awarded team of the year for 2015.

Public and staff engagement

- Patient opinion was gathered using the Patient Led Assessment of the Care Environment audit, which was completed on an annual basis within the hospital.
- Hospital wide staff survey results showed a positive increase in 2015 on 2014 results. The highest scoring categories in the 2015 staff survey were individual's work which scored 87%, 'engagement' which scored 86% and 'my manager' which scored 81%.
- The least positive element of the hospital wide staff survey was in relation to 'working together' which scored just 38%, the second lowest score from the staff survey was in relation to 'senior leadership' which scored 46%.
- Staff reported that the top priority in their hospital was to deliver the highest quality of patient care, and this had increased from 2014 by 5% to 93%. Staff who would recommend the hospital to friends or family for treatment received the same positive score of 93%.
- Patient surveys were used in outpatient and diagnostic imaging services to develop and improve patient services and staff gave us examples of improvements made because of survey feedback in both services.

Innovation, improvement and sustainability

- Diagnostic imaging used a colour coding system which staff used to identify which service each patient was waiting for so that patients weren't unnecessarily disturbed whilst waiting for their appointments.
- A member of senior nursing staff within the outpatient department had designed and was in the process of

piloting an outpatient specific patient survey. At the time of inspection this was about to be trialled, and feedback was to be shared with the relevant heads of department, to enable on-going improvements to be made to patients' experience.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital responded promptly to all areas of concern raised during our inspection, with changes noted on our unannounced visit.
- Specialist breast care nurses supplied leaflets and underwear catalogues to patients who had undergone significant breast surgery. The information was specifically to help patients regain self-confidence as part of their post-operative recovery.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure that within the theatre department, improvements made concerning equipment and the World Health organisation (WHO) Five Steps to Safer Surgery checklist are sustainable.
- Review the Royal College of Surgeons professional standards on consultation for cosmetic surgery and ensure it is working in line with these standards.
- Consider the adequacy of the low compliance target for the percentage of patients being correctly fasted prior to surgery.
- Consider the effectiveness of action planning and follow up to demonstrate improvements.
- Hospital wide and departmental risk registers should be reviewed to ensure that they correlate, and should have a method for capturing review dates, recommendations, actions, responsible individuals, deadlines and dates of completion of actions.